

Registration District No. 18 1940

Primary Registration District No. 6143

Registrar's No.

## 1. PLACE OF DEATH:

(a) County Texas  
(b) City or town Rural Cass Twp  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2  
(Specify whether  
In this community years, months or days) 600

## 3. (a) PRINT

FULL NAME Tennessee Carry

## 3. (b) If veteran,

name war

## 3. (c) Social Security

No.

4. Sex F

## 5. Color or

race W

## 6. (a) Single, widowed, married,

divorced ✓6. (b) Name of husband or wife Will

## 6. (c) Age of husband or wife If

alive

years

7. Birth date of deceased Dec 22

(Month)

(Day)

(Year) 1864

## 8. AGE:

Years 75Months 1Days 20

If less than one day

hr.

min.

## 9. Birthplace

(City, town, or county)

(State or foreign country) Texas10. Usual occupation Housewife

## 11. Industry or business

MOTHER FATHER

12. Name Wright Miller

## 13. Birthplace

(City, town, or county)

(State or foreign country) unknown14. Maiden name unknown

## 15. Birthplace

(City, town, or county)

(State or foreign country) unknown16. (a) Informant's own signature Bill Williams(b) Address R. 2 Cabool Mo17. (a) Burial

(Burial, cremation, or removal)

(b) Date thereof Feb 14 1940

(Month) (Day) (Year)

(c) Place: burial or cremation Miller Cemetery Cass Twp18. (a) Signature of funeral director Gaylord L. Elliott(b) Address Cabool Mo19. (a) Feb 14 - 1940

(Date received local registrar)

(b) Mrs. Lou Ma. Miller

(Registar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Texas  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. 0  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. 7 years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 12  
year 1940 hour 8 minute P M.

21. I hereby certify that I attended the deceased from January 10  
1940 to Feb 12 1940  
that I last saw her alive on Feb 12 1940  
and that death occurred on the date and hour stated above.

## Immediate cause of death

Myocarditis  
Due to Comp. Lab. P. mumm.

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings:

Of operations

Of autopsy

## Duration

## PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically

## 22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (Specify)  
(b) Date of occurrence Feb 14 1940  
(c) Where did injury occur? 0  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work

(Specify type of place)

(e) Means of injury

23. Signature E. H. Gual (M. D. or other)  
Address Cabool Mo Date signed 2-13-40

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

**RECEIVED**  
District Health Officer No. 5,

District File Number 840245

Date Filed 3840

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 8425-7

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 865

Primary Registration District No. 6143

Registrar's No. ....

1. PLACE OF DEATH:

(a) County Texas  
(b) City or town Temp.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
(Specify whether  
In this community.....  
years, months or days)

3. (a) PRINT  
FULL NAME Tennessee Curry

3. (b) If veteran, name war..... 3. (c) Social Security No. ....

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year  
7. Birth date of deceased.....  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
75 1 20 h. min.

9. Birthplace.....  
(City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....  
13. Birthplace.....  
(City, town, or county) (State or foreign country)  
14. Maiden name.....  
15. Birthplace.....  
(City, town, or county) (State or foreign country)

16. (a) Informant.....  
(b) Address.....

17. (a)..... (b) Date thereof.....  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....  
(b) Address.....

19. (a) Feb 16-1940 (b) Mrs Lou MaMillan  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....  
(c) City or town.....  
(If outside city or town limits write "RURAL")  
(d) Street No.....  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.?..... years.

20. DATE OF DEATH Month Feb day 12  
year 1940 hour..... minute..... M.

21. I hereby certify that I attended the deceased from.....  
19....., to..... 19.....;  
that I last saw h..... alive on..... 19.....;  
and that death occurred on the date and hour stated above.  
Immediate cause of death.....

Due to.....  
Due to.....

Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations.....  
Of autopsy.....

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify).....  
(b) Date of occurrence.....  
(c) Where did injury occur?.....  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?..... (Specify type of place)  
(e) Means of injury.....

23. Signature L M Dillman (M. D. or other)  
Address..... Date signed.....

Duration

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

تاریخ: ۱۳۰۲

2000-01-01